K A N S A S

RODERICK L. BREMBY, SECRETARY KATHLEEN SEBELIUS, GOVERNOR
DEPARTMENT OF HEALTH AND ENVIRONMENT

M E M O R A N D U M

TO: Local Health Agencies
Other Grantees

FROM: Roderick L. Bremby, Secretary

DATE: January 14, 2005

RE: Grant / Contract Reporting Instructions
SFY 2006

The attached material outlines the process and format for preparation of the Grant / Contract quarterly reports beginning July 1, 2005. Please read the attached instructions for the individual Contract Attachments and the Notice of Grant Award Amount & Summary of Program Objectives before preparing your quarterly reports.

These instructions supercede all previous Grant / Contract Quarterly Report Instructions. You are advised to destroy any previous instructions and use these to ensure accurate and timely reporting which will permit a timely cash flow to you: the grantee. If your agency is reporting electronically, please amend the electronic form(s) appropriately.

If it is necessary to file an amended quarterly report, a brief letter of explanation should accompany the amended report. The report must be signed and dated by the person authorized to sign for your local health agency. If you are reporting electronically, the name of the authorized person must be typed on the appropriate line. Amended reports are required to be filed within 90 days following the end of the appropriate program quarter.

If you have any questions or concerns about the reporting requirements, please contact Kevin Shaughnessy, Accounting Services at (785) 296-1507 at your earliest convenience. Your continued cooperation in this matter is greatly appreciated.

Enclosure
pc: Richard Morrissey, Interim Director of Health

INTERNAL MANAGEMENT
PURCHASING AND ACCOUNTING SERVICES
CURTIS STATE OFFICE BUILDING, 1000 SW JACKSON ST., STE 570, TOPEKA, KS 66612-1368
VOICE 785-296-1524 FAX 785-296-8465 Http://www.kdhe.state.ks.us

TABLE OF CONTENTS

Page

HIV Counseling and Testing Program (POS #14)
STD / AIDS Disease Intervention / Prevention Services (POS #15)
Child Care License and Registration (POS #18, #26)
HIV Enhanced Prevention Counseling and Testing (POS #22)
AIDS HERR CBO's Substance Abusers (POS #30)
HIV/AIDS Case Management/Prevention Case Management (POS #33)
Immunization Action Plan (POS #34)
HIV Prev Outreach by CBO's to Gay/Bisexual Men (POS #36)
Special Grants (as awarded):
Hypertension in African-American Community
Kansas Council on Fitness
Rape Prevention/Crisis Intervention

5 Child Care Licensing & Registration Child Care Development Block Grant Program Report
6 M&I Perinatal Outcome Data - Semi-Annual Report
7 **Affidavit of <u>Revenues</u> and Expenditures:**

Family Planning (POS #5)
Teenage Pregnancy Reduction (POS #8)
Comprehensive School Health Centers: (POS 9)
Maternal & Child Health Services(POS #17)
Teen Pregnancy Prevention Peer Education (POS #28)
Teen Pregnancy Case Management (POS #32)
Special Grants (as awarded):
Disparity Initiative
Abstinence Education

8 Family Planning Semi-Annual Report
9 Enhancement/Chronic Disease Risk Reduction Program (CDRR) Semi-Annual Report
#10 Aid to Local Match Requirements
#11 Individual Professional Development Plan
#12 HIV AIDS Confidential Case Report

A. Adult HIV/AIDS Confidential Case Report
B. Pediatric HIV/AIDS Confidential Case Report

#13 Contractor Reporting Form, HIV Case Management/Prevention Case Management
#14 Key Code by Fund & CFDA #
#15 Grant Manager's Quarterly Expenditure Report:
#16 Line Item Adjusted Budget Summary
#17 Director's Progress Report (narrative)

OUTLINE OF REPORTING INSTRUCTIONS:

Reports required for grants / contracts awarded to Local Health Agencies for State Fiscal Year 2006 are explained in the following material. Reporting requirements have been revised in order to meet individual program requirements.

The quarterly/semi-annual program and fiscal report (Certified Affidavit of Expenditures) should be viewed as one report. The material that makes up the report should all be submitted at the same time because program and fiscal staff will make a joint review. Future payments will not be made until the total report is received and approved.

The reporting periods should be on a schedule corresponding with the funding period which is the State Fiscal Year (SFY July 1 through June 30). The suggested reporting schedule is as follows:

REPORTING SCHEDULE

1st Quarter	7/1 to 9/30	REPORT DUE	October 15th
2nd Quarter	10/1 to 12/31	REPORT DUE	January 15th
3rd Quarter	1/1 to 3/31	REPORT DUE	April 15th
4th Quarter	4/1 to 6/30	REPORT DUE	July 15th

The following instructions are for developing and submitting the quarterly/semi-annual reports.

Quarterly fiscal reports **(*Certified Expenditure Affidavit)** are due at Department of Health and Environment **by the 15th of the month following the quarter**, e.g., July - September, due October 15th. No annual reports are required. Program reports should be submitted as specified within each Contract Attachment / Notice of Grant Award Amount & Summary of Program Objectives.

Unless indicated otherwise, **submit two (2) copies (ORIGINAL PLUS 1 COPY) of the program/fiscal reports are to be mailed to:**

Kevin Shaughnessy, Accountant
Internal Management/Accounting Services
1000 Jackson Ave, Suite 570
Department of Health and Environment
Topeka, KS 66612-1368
Phone: (785) 296-1507
email: kshaughn@kdhe.state.ks.us

If affidavits are submitted electronically, it is not necessary to mail them.

Note: Audit reports are also mailed to Kevin Shaughnessy.

* Certified Expenditure Affidavits # 1, #2, #4, and #7 can be downloaded from the KDHE Website at: http://www.kdhe.state.ks.us/doc_lib/index.html.
Department of Health and Environment

PROGRAM REPORTING:

A. STATE FORMULA FUNDS REPORT:

1. No narrative reports are required.

2. **QUARTERLY:** Submit a Certified Affidavit of Expenditures (Attachment #1). This requires reporting of total local tax and other non-state, non-federal revenue and expenditures.

   Fiscal reporting instructions are explained in Sections Q., R., and S.

3. **PROGRAM CONTACT PERSON**

   Shirley Orr, Director, Local Health
   Office of Local & Rural Health
   Curtis State Office Building
   1000 SW Jackson, Suite 340
   Topeka, KS 66612-1365
   Phone: (785) 296-1200
   Fax: (785) 296-1231
   e-mail: sorr@kdhe.state.ks.us

B. COMMUNITY-BASED PRIMARY CARE REPORT

1. **GENERAL REPORTING INSTRUCTIONS:** The general instructions for completing the Quarterly Program Progress Reports for Community-Based Primary Care are as follows:

   Read all instructions and definitions immediately.

   a. Begin collecting data for Fiscal Year 2006 on July 1, 2005, according to the following definitions if you are not already doing so. If you cannot use the state fiscal year as the start of a 12-month reporting period, designate and record another start date for your local statistical year.

   b. We realize your first responsibility is providing health care, not collecting data. It is not our desire to place an unnecessary burden on any of the clinics by asking for data in a specific format. However, by standardizing the definitions, we can better use the data in a manner that benefits all of the clinics. Thus, if you are unable to collect the data as specified in this evaluation, please let us know as soon as possible.

2. **PROGRAM PROGRESS REPORT:** Please use the Jan 2005 revision of the Quarterly Report Form (Attachment #2, page 1). Copies may be duplicated or additional report forms can be requested from Office of Local and Rural Health (OLRH) at (785) 296-1200 or the form may be found on the KDHE website: http://www.kdhe.state.ks.us/olrh/pc.htm

   The following sections give instructions for completing each table in the Quarterly Report. Please refer to the definitions as you are completing the evaluation.

   a. **GRANT/CLINIC NAME:** If a grantee operates clinics at more than one location, please report separately and record the clinic name and location on each report form. If there are more than one clinic but all the data is compiled together in one report, write in the name of the grantee only.

   b. **REPORT PERIOD:** The reporting period is three months on a schedule corresponding with the funding period which is the State Fiscal Year (SFY July 1 - June 30). Check the appropriate quarter at the top of each report page or indicate the dates of the reporting period if appropriate. The report is due fifteen days after the quarter ends, (i.e., on the fifteenth of the month following the end of the quarter) The reporting cycle may also be found on the web at: http://www.kdhe.state.ks.us/olrh/pc.htm

   c. **REPORTING SCHEDULE:**

1st Quarter	7/1 to 9/30	REPORT DUE	October 15
2nd Quarter	10/1 to12/31	REPORT DUE	January 15

3rd Quarter	1/1 to 3/31	REPORT DUE	April 15
4th Quarter	4/1 to 6/30	REPORT DUE	July 15

d. **CLINIC USERS** (Table 1)

Clinic Users (Unduplicated Count): To reduce your reporting burden, **this number may now be reported only at the end of the 12-month counting period to provide the annual count of individual clinic users.** We need this number to understand the impact clinics are having on health care access across the state and to be consistent with data collected nationwide on the number of "encounters" (or visits) relative to and the number of "users" (total number of individual clients, counted only once).

e. **BREAKDOWN BY AGE AND SEX** (Table 2)

Quarterly reporting of patient visits will be by age group and gender: indicate the number of male visits, female visits, and total visits. A visit is defined as a face-to-face professional encounter or consultation in the clinic in which some type of therapeutic transaction took place. Count each face-to-face consultation with a separate provider as a separate visit even if a client sees both of them on the same day. A count of visits should NOT include front-desk referrals.

CHECK: The lower right-hand block in this table should be the sum total of the above preceding age-group subtotals as well as the sum of the male and female visits. This number should also represent total clinic visits for the stated reporting period.

f. **BREAKDOWN BY PAYMENT SOURCE** (Table 3)

Payment Source: Report visits by a source of payment with each client visit assigned to only one of the four categories: Private Pay, Medicaid, HealthWave (separate from Medicaid, if possible) and Medicare, and Other Insurance.

Private Pay: Count visits by clients with no insurance who "self-pay" established minimum clinic fees or reduced fees based upon household income. This category may also include clients who have private insurance but who choose to pay discounted clinic fees rather than file an insurance claim, those who must meet a deductible or high co-payment before insurance will pay, and those whose insurance will not cover the services provided by the clinic. If, for example, your clinic serves only clients with no health insurance, then all of your client visits will fall into this category. Visits: Provide a count of all visits. A visit is defined as a face-to-face consultation with one or more on-site clinical personnel in which a therapeutic transaction took place.

CHECK: Total Visits should be the sum of the preceding four Payment

Source visit subtotals in Table 3. It should match the total Visits by Age and Sex in Table 2 and the total visits by Poverty Level in Table 4. This count represents the total number of clinic visits for the stated reporting period.

g. **VISITS BY POVERTY LEVEL** (Table 4)
For each of the categories, indicate the number of client visits. All clients should fall into only one of the four categories.

CHECK: Total Visits should be the sum of the preceding four visit subtotals. This count represents the total number of clinic visits for the stated reporting period.

3. **AFFIDAVIT OF EXPENDITURES:** Community-Based Primary Care Program (Attachment #2, page 2-3). Follow KDHE General Accounting Services instructions in Sections Q., R., and S. Additional instructions for the Community-Based Primary Care grants are explained as follows:

a. **Staff Personnel:** Staff Salaries and Benefits.
List personnel according to a category (e.g., health professionals /clinical staff, clerical, administrative). Beneath the category "health professional/clinical staff" each position should be listed separately by title and percent of full-time equivalency (FTE) employed as a primary care provider. Allocate the salary amounts to be paid from local health agency shares in the column labeled "Local Match Amount" and/or State Grant in the "Grant Amount" column. Include regularly assigned personnel who receive salaries or wages and volunteers routinely scheduled to work at least 20 hours per week in the Staff Personnel category. Include expenses of payroll taxes and employer-paid benefits.

Health professional/clinical staff includes physicians, and all nursing personnel (RN, LPN, nursing assistants) nurse practitioners and physicians' assistants, dentists, dental hygienists, mental health professionals, and optometrists.

b. **Contract Personnel:** Health Professionals who are not employees.
Contract Personnel are health professionals (listed above) who provide primary care services by special arrangement or contract. The full time equivalency (FTE) of the contracted person should be shown in the column marked "% time worked in a program." Include paid contract staff as well as volunteers who work irregularly or less than 20 hours per week. Show dollar amounts in appropriate column for revenue sources. List the value of donated services in the Local Applicant Share.

c. **Health Services:** Payments made for services only, not personnel.
Health Services include payments for the following: dental, vision, hearing,

laboratory, pharmacy, mental health, and radiology service. Do not record salaries or wages of personnel who provide those services. For each service, separate costs according to costs associated with locally purchased or donated services (Local Match Amount) and costs which are covered by the state grant. The local applicant's share may not be more than the actual cost of the service for which the agency has paid. For example, the cost to report for donated (non-cash) laboratory services should be an amount agreed upon as the market value for those services.

d. **Travel:**
Include in-state travel to primary care training and continuing education in this category. Do not include salary expense. State grant funds may not be used for out-of-state travel.

e. **Supplies:**
Categorize supplies according to type-- Pharmaceuticals (prescription medications purchased by or dispensed from the clinic site) Laboratory Supplies, (Other Medical Supplies: patient education materials, and clinical supplies directly related to patient services, e.g., drapes, needles), and Office Supplies (clerical, financial, administrative and other operational supplies). Do not include a cost (value) for donated sample medications.

f. **Capital Equipment:**
Capital Equipment is defined as items costing $500 or more and having a useful life greater than one year. Avoid budgeting for capital equipment with state funds without prior authorization from the program manager. If capital items purchased with local funds are to be credited toward the local match, they must be listed separately. Capital equipment purchases should be approved at the time of the annual budget. Other expenditures require written authorization from the state program director. Each capital item purchased with grant funds must be listed separately with the manufacturer, model and serial number of the item, if appropriate, and copy of an invoice or receipt.

g. **Other: (Including Indirect Cost)**
Itemize other direct costs. Indirect costs or contributions are acceptable only as part of the local match, but the agency must submit an annual indirect cost proposal which meets KDHE requirements. Items included in the indirect cost computation cannot be included as direct cost items. Indirect costs may include rent, utilities, insurance, dues, subscriptions, audit related costs, and general administration.

h. **Affidavit Total:**
Find affidavit total for each column by adding the subtotals of categories 4 through 10. The Local Match Amount plus the Grant Amount should

equal the Total Amount.

4. **Mailing:**
MAIL two copies (original plus one copy) of the Quarterly Program and Fiscal Reports to:

Kevin Shaughnessy, Accountant
Internal Management/Accounting Services
Kansas Department of Health and Environment
1000 SW Jackson, Ste. 570
Topeka, KS 66612-1368
Phone: (785) 296-1507

5. **Program Contact Person:**
Barbara Gibson, Director, Primary Care Service
KDHE, Office of Local & Rural Health
1000 SW Jackson, Suite 340
Topeka, KS 66612-1365
phone: (785) 296-1200
fax: (785) 296-1231
email: bgibson@kdhe.state.ks.us

C. CHILD CARE LICENSING & REGULATION PROGRAM

1. **QUARTERLY:** submit the Certified Affidavit of Expenditures (Attachment #4). State grant funds cannot be used to purchase Capitol Equipment.

2. **QUARTERLY:** submit the original of the standardized report form. Specific instructions in completing the form are as follows for those sections which are not self-explanatory. See Attachment #5.

ATTACHMENT #5: the following items refer to categories to be completed.

Contractor: Place the name of the **contracting county** or the **private** contractor on this line.

Counties in Service Area: Multi-County contractors are required to **complete one report for each county**. List the county this report represents.

Report Period: Place the dates of the report period on this line. (Example: 07/01/2005 to 09/30/2005 for 1st report.) **Please do not designate the quarter as 1st, 2nd, etc. due to the conflict between SFY and county FY calendars. Data entry requires mm/dd/yy reporting.**

The following "letters and numerals" refer to categories to be completed on Attachment #5.

A.1. This should be the total number of group orientation sessions for home providers held during the quarter.

1.a. This should be the total number of persons attending the initial orientation group sessions who are interested in a day care home facility (licensed or registered).

1.b. This should be the frequency of orientation sessions for persons interested in a day care home facility (licensed or registered). If at least **one person** applies/requests orientation information per month, the required minimum frequency is monthly. If application/orientation requests are less frequent, they should be given immediately (upon demand).

A.2. This should be the total number of **group** orientation sessions for persons interested in a child care center facility including Preschools and School Age Programs.

2.a. This should be the total number of persons attending the initial orientation group sessions who are interested in a child care center facility including preschools and school age programs.

2.b. This should be the frequency of orientation sessions for persons interested in a child care center facility including preschools and school age programs. If at least **one person** applies/requests

orientation information per month, the required minimum frequency is monthly. If application/orientation requests are less frequent, they should be given immediately (upon demand).

A.3. Indicate the number of individual consultations held for persons wanting to open a child care facility in addition to the initial orientation sessions for:
a. Home providers
b. Center/Preschool facilities.

B.1. This should be total number of initial applications received this quarter and forwarded to KDHE for processing.

C.1. Report here the total number of initial surveys conducted during the report period. (If more than one on-site visit is required to complete the survey, the count is one.) Follow up visits (compliance checked) are counted in C.2.
C.2. Report here the total number of successful follow up visits (to initial surveys) conducted during the report period.
C.3. Report here the total number of renewal or re licensing surveys conducted during the report period. (If more than one on-site visit is required to complete the survey, the count is one.) Follow up visits are counted in C 4.
C.4. Report here the total number of successful follow up visits (compliance checks to renewal surveys) during the report period.
C.5. The number reported here should be the total number of successful KDHE requested compliance check visits made--contact occurred.

D.1.a. Report here the number of illegal child care complaint intakes investigated during the report period.
D.1.b. Report here the number of child care complaint intakes alleging regulation violations investigated during the report period.

E.1. Report here the number of families referred to licensed child care resource and referral agencies.

F.1.a. Report the type of Outbreak (the definition of an outbreak will be according to the CDC protocols).
F.1.b. Report the program type in which the outbreak occurred.
F.1.c. (1) Report the number of children affected in this outbreak.
(2) Report the number of staff affected in this outbreak.
F.2.a. -- d. (2) Report as in F.1. Report any further outbreaks in the Narrative.

G.1.a. Report the type of Serious Injury or Cause of Death
G.1.b. Report the license of certificate number of the regulated facility.

H.1. Report the provider in service training which you co-sponsored, sponsored or provided directly--workshops only. Using the Core Competencies for Early

Childhood Care and Education Professionals in Kansas and Missouri, identify the content area, level of competency, and all other information as requested for each workshop.

I. 1. For presentations you conducted to community groups/organizations about the child care regulatory program **but not including workshops to providers listed in I. above,** report the Topic of the presentation, the community group or organization name and the number of persons attending the presentation.

I.2. Report the number of advertisements directly related to local child care regulatory services published during the report period.

I.3.a. Report the number of articles published during the report period. Include copies.

I.3.b. Report the topic(s).

I.4.a.--b. Report the number of brochures distributed and the topic(s)

I 5.a.--b. Report the number of posters produced and posted and the topic(s).

I.6. Report on any other community partnership activities that are not listed elsewhere. Include names of community agencies/organizations involved, a brief description of the project, meeting or other information, number of persons involved.

J. Narrative. Include a narrative of local child care regulatory activity; outline progress in meeting local program objectives, any program changes, challenges, innovative work or special projects, etc.

3. **PROGRAM CONTACT PERSON**

Janet Newton, MS
Administrator, Child Care Unit
Bureau of Child Care and Health Facilities
Curtis State Office Building
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
phone: 785-296-1270
fax: 785-296-0803
email: jnewton@kdhe.state.ks.us

D. MATERNAL AND CHILD HEALTH SERVICES

1. **DETAILED CLIENT ENCOUNTER DATA COLLECTION:** Submit detailed client encounter data in a timely manner, in either paper or electronic format in accordance with the guidance provided by the Children and Families Section, BCYF.

2. **QUARTERLY:** Submit the Certified Affidavit of Revenues and Expenditures (Attachment #7). Refer to the Fiscal Reporting in Sections Q., R., and S. In addition, agencies must submit a Narrative Report (See Attachment #3) covering the 3 months of the quarter that includes:
    - Areas of greatest need within your community and objectives identified to address those needs.
    - Strategies implemented to meet identified objectives.
    - Assets in your community that assisted in meeting the objectives.
    - Challenges encountered in meeting your objectives.
    - Data sources used for tracking progress on objectives.
    - Progress in meeting contract objectives.
    - Local health agency concerns and needs.
    - Changes or additions to local policies/procedures.
    - Staff changes.
    - Pertinent client case examples.
    - Special results of program interventions.

3. **MID-YEAR**: Grantees providing services to pregnant women must submit the Perinatal Outcome Data form (Attachment #6) covering the first six months of the contract period.

4. **END-OF-YEAR**: Submit a Narrative Summary Report covering the entire contract period. See D.2. for content.

    Grantees providing services to pregnant women must submit the Perinatal Outcome Data form (Attachment #6) with the end-of-year report covering the entire contract period.

    Grantees providing family outreach and support services in the home will provide at least 20% of the families with a postcard. The family completes the card and mails it to KDHE for review and feedback to the local health agency.

5. **IPDP:** All MCH staff must have an Individual Professional Development Plan (IPDP) on file at each agency (See Attachment 11).
    - Healthy Start Home Visitors must attend five in-service trainings per year; including at least two mandatory trainings provided by KDHE.

6. **COMPLIANCE MONITORING**: Monitoring/Site Visits will be conducted and technical assistance will be provided to all MCH grantees by KDHE staff.

7. **PROGRAM SPECIFICS**: Income and family size of all MCH clients must be verified at least annually.
   - A sliding fee scale with a minimum of four equal increments must be established and implemented for all MCH provided services.
   - **A 5% penalty of total grant award amount will be assessed for delinquent year end reports beyond August 15th. NO EXCEPTIONS!**

8. **PROGRAM CONTACT PERSONS**

Primary Contacts:

Chris Tuck, Child Health	(785) 296-7433
ctuck@kdhe.state.ks.us	
Jane Stueve, Adolescent Health	(785) 296-1308
jstueve@kdhe.state.ks.us	
Joe Kotsch, Maternal Health	(785) 296-1306
jkotsch@kdhe.state.ks.us	
Jamie Klenklen, Administrative Consultant	(785) 296-1234
jklenklen@kdhe.state.ks.us	

E. FAMILY PLANNING

1. **DETAILED CLIENT ENCOUNTER DATA COLLECTION:** Submit detailed client encounter data in a timely manner, in either paper or electronic format in accordance with the guidance provided by the Children and Families Section, BCYF.

2. **QUARTERLY**: submit the Certified Affidavit of Revenues and Expenditures (Attachment #7). Refer to the Fiscal Reporting in Sections Q., R., and S.

3. **MID-YEAR**: submit a completed Family Planning Semi-Annual Report (format - Attachment #8) covering the first 6 months of the contract. All sections of this report must be addressed: Exam Time, Chart Audit, Abnormal Pap Results, HIV Reporting, and Program Narrative.

   The Family Planning Semi-Annual Report should be mailed directly to the Family Planning Administrative Consultant (listed below).

4. **END-OF-YEAR**: submit a completed Family Planning Semi-Annual Report (format - Attachment #8) covering the last 6 months of the contract (See E. 3. for content) and a copy of the current family planning schedule of fees and discounts. The Family Planning schedule of fees and discounts must be established and implemented on proportional increments according to the federal guidelines.

   The Family Planning Semi-Annual Report and schedule of fees and discounts should be mailed directly to the Family Planning Administrative Consultant (listed below).

5. The local health agency will distribute a client satisfaction survey card to every 5th client (20%). Postage-paid cards are supplied to the local health agency by KDHE. The client completes the card and mails it to KDHE for review and feedback to the agency.

6. **PROGRAM CONTACT PERSON**

   Janis Bird, Family Planning Administrative Consultant (785) 296-1205
   jbird@kdhe.state.ks.us

   Ruth Werner, Family Planning Director (785) 296-1304
   rwerner@kdhe.state.ks.us

F. TEENAGE PREGNANCY REDUCTION (previously known as ADOLESCENT HEALTH - TEEN PREGNANCY REDUCTION PROGRAM (TPRP))

1. **QUARTERLY**: submit a Certified Affidavit of Revenues and Expenditures (Attachment #7). Refer to the Fiscal Reporting in sections Q., R., and S.

2. **MID-YEAR**: submit a Narrative Report to the program contact person for the first 6 months of the contract that includes:
   - Areas of greatest need within your community and objectives identified to address those needs.
   - Strategies implemented to meet identified objectives.
   - Assets in your community that assisted in meeting the objectives.
   - Challenges encountered in meeting your objectives.
   - Data sources used for tracking progress on objectives.
   - Progress in meeting contract objectives.
   - Local health agency concerns and needs.
   - Changes or additions to local policies/procedures.
   - Staff changes.
   - Pertinent client case examples.
   - Special results of program interventions.

3. **END-OF-YEAR**: submit a Narrative Report to the program contact person covering the last 6 months of the contract. Refer to F.2. for content.

   Exception: Progress in meeting contract objectives should be reported for the full 12 month period. The local health agency should list: 1) objectives from the contract; and 2) project achievements.

4. Attend annual program evaluation meeting held during the summer by the program contact person and provide a brief presentation of the program's achievements.

5. **PROGRAM CONTACT PERSON**
   Jane Stueve, Adolescent Health (785) 296-1308
   jstueve@kdhe.state.ks.us

G. COMPREHENSIVE SCHOOL HEALTH CENTERS (previously know as School-Linked Services or ADOLESCENT HEALTH - SCHOOL-LINKED SERVICES)

1. **DETAILED CLIENT ENCOUNTER DATA COLLECTION:** Submit detailed client encounter data in a timely manner, in either paper or electronic format in accordance with the guidance provided by the Children and Families Section, BCYF.

2. **QUARTERLY**: submit a Certified Affidavit of Revenues and Expenditures (Attachment #7). Refer to the Fiscal Reporting in sections Q., R., and S.

3. **MID-YEAR**: submit a Narrative Report to the program contact personfor the first 6 months of the contract that includes:
   - Areas of greatest need within your community and objectives identified to address those needs.
   - Strategies implemented to meet identified objectives.
   - Assets in your community that assisted in meeting the objectives.
   - Challenges encountered in meeting your objectives.
   - Data sources used for tracking progress on objectives.
   - Progress in meeting contract objectives.
   - Local health agency concerns and needs.
   - Changes or additions to local policies/procedures.
   - Staff changes.
   - Pertinent client case examples.
   - Special results of program interventions.

4. **END-OF-YEAR**: submit a Narrative Report to the program contact person covering the last 6 months of the contract. Refer to G.3. for content.

   Exception: Progress in meeting contract objectives should be reported for the full 12 month period. The local health agency should list: 1) objectives from the contract; and 2) project achievements.

5. **PROGRAM CONTACT PERSON**
   Jane Stueve, Adolescent Health (785) 296-1308
   jstueve@kdhe.state.ks.us

H. TEEN PREGNANCY CASE MANAGEMENT (TPCM)

1. **QUARTERLY**: submit:
   a. Certified Affidavit of Revenues and Expenditures (Attachment #7). Refer to the Fiscal Reporting in Sections Q., R., and S.
   b. Quarterly outcomes/indicators form.
   c. TPCM Data Forms. Refer to the Teen Pregnancy Case Management Manual for forms.

Two (2) copies (original plus one copy) of fiscal reports are to be mailed to KDHE's Internal Management/Accounting Services (listed in "Outline of Reporting Instructions"). Submit one copy of quarterly outcomes/indicator form to program contact person (listed below).

2. **MID-YEAR**: submit a Narrative Report to the program contact person for the first 6 months of the contract that includes:
   - Areas of greatest need within your community and objectives identified to address those needs.
   - Strategies implemented to meet identified objectives.
   - Assets in your community that assisted in meeting the objectives.
   - Challenges encountered in meeting your objectives.
   - Data sources used for tracking progress on objectives.
   - Progress in meeting contract objectives.
   - Local health agency concerns and needs.
   - Changes or additions to local policies/procedures.
   - Staff changes.
   - Pertinent client case examples.
   - Special results of program interventions.

3. **END-OF-YEAR**: submit a Narrative Report to the program contact person covering the last 6 months of the contract. Refer to H.2. for content.

   Exception: Progress in meeting contract objectives should be reported for the full 12 month period. The local health agency should list: 1) objectives from the contract; and 2) project achievements.

4. Attend annual program evaluation meeting held during the summer by the program contact person and provide a brief presentation of the program's achievements.

5. **PROGRAM CONTACT PERSON**
   Jane Stueve, Teen Pregnancy Prevention (785) 296-1308
   jstueve@kdhe.state.ks.us

I. TEEN PREGNANCY PREVENTION PEER EDUCATION (previously known as TEEN PREGNANCY PREVENTION - PHASE II (TPII))

1. **QUARTERLY**: submit:
   a. Certified Affidavit of Revenues and Expenditures (Attachment #7). Refer to the Fiscal Reporting in Sections Q., R., and S.
   b. Quarterly outcomes/indicators form.

Two (2) copies (original plus one copy) of fiscal reports are to be mailed to KDHE's Internal Management/Accounting Services (listed in "Outline of Reporting Instructions"). Submit one copy of quarterly outcomes/indicator form to the program contact person (listed below).

2. **MID-YEAR**: submit a Narrative Report to the program contact person for the first 6 months of the contract that includes:
   - Areas of greatest need within your community and objectives identified to address those needs.
   - Strategies implemented to meet identified objectives.
   - Assets in your community that assisted in meeting the objectives.
   - Challenges encountered in meeting your objectives.
   - Data sources used for tracking progress on objectives.
   - Progress in meeting contract objectives.
   - Local health agency concerns and needs.
   - Changes or additions to local policies/procedures.
   - Staff changes.
   - Pertinent client case examples.
   - Special results of program interventions.

3. **END-OF-YEAR**: submit a Narrative Report to the program contact person covering the last 6 months of the contract. Refer to I.2. for content.

   Exception: Progress in meeting contract objectives should be reported for the full 12 month period. The local health agency should list: 1) objectives from the contract; and 2) project achievements.

4. Attend annual program evaluation meeting held during the summer by the program contact person and provide a brief presentation of the program's achievements.

5. **PROGRAM CONTACT PERSON**
   Jane Stueve, Adolescent Health (785) 296-1308
   jstueve@kdhe.state.ks.us

J. AIDS HEALTH EDUCATION/RISK REDUCTION (AIDS HE/RR)

1. Awards are initiated upon receipt of an amended budget unless the award is equal to the requested amount.

2. **QUARTERLY:** submit HIV HE/RR electronic web-based reports per program guidance which includes a description of all HIV HE/RR activities based on the contractors approved work plan. Web-based reporting requirements shall be kept up to date during the quarterly reporting periods with data entry occurring as soon as possible after activity in conjunction with grants manager guidance.

   Agencies are required to assess the impact of program activities through outcome monitoring and use this information to plan and improve future activities/programs.

3. **QUARTERLY:** submit the Certified Affidavit of Expenditures (Attachment #4). Fiscal reporting instructions are explained in sections Q., R., and S.

4. **QUARTERLY:** for grant #36 submit the following forms to the appropriate Grants Manager:
   - Grants Manager's Quarterly Expenditure Report (Attachment #15)
   - Line Item Adjusted Budget Summary (if applicable) (Attachment #16)
   - Director's Progress Report (Narrative) (Attachment #17)

5. **PROGRAM CONTACT PERSON**
   Kathy Donner, HIV Prevention Director
   Bureau of Epidemiology & Disease Prevention
   (785) 296-5223

   GRANTS MANAGERS
   Ron Miller, Prevention Grants Manager
   Regions 1-4 & Sedgwick County in Region 8
   Kansas Department of Health and Environment
   Bureau of Epidemiology & Disease Prevention
   HIV/STD Section
   1000 SW Jackson, Suite 210
   Topeka, KS 66612 Phone: (785) 296-6542

   Mary Sutton, Prevention Grants Manager
   Regions 5-9 & all counties other than Sedgewick Co. Region 8
   Kansas Department of Health and Environment
   Bureau of Epidemiology & Disease Prevention
   HIV/STD Section
   130 South Market, Suite 6050
   Wichita, KS 67202 Phone: (316) 337-6135

K. HIV COUNSELING AND TESTING PROGRAM

1. **QUARTERLY:** Submit web based reporting for all HIV tests performed as soon as possible after activity performed.

2. **QUARTERLY:** submit the Certified Affidavit of Expenditures (Attachment #4). Fiscal reporting instructions are explained in sections Q., R., and S.

3. Within 30 days of testing positive for HIV-infection, submit documentation of referral and/or service provision for the HIV-positive client using the CDC Case Report. See (Attachments #12).

4. **PROGRAM CONTACT PERSON**
   Jennifer Vandevelde
   HIV Counseling and Testing
   Bureau of Epidemiology & Disease Prevention (785) 296-6544

L. HIV ENHANCED COUNSELING AND TESTING

1. **QUARTERLY:** Submit web-based reporting for all HIV tests performed as soon as possible after activity performed.

2. **QUARTERLY:** Submit the Certified Affidavit of Expenditures (Attachment #4). Fiscal Reporting instructions are explained in sections Q., R., and S.

3. **EACH POSITIVE TEST**: At the time of a rapid HIV positive test, client will be referred for confirmatory testing to determine an HIV positive test result. HIV case reporting, disease intervention follow-up and referral to care services is required for all confirmed HIV positive clients.

4. **PROGRAM CONTACT PERSON**
   Jennifer Vandevelde
   HIV Counseling and Testing
   Bureau of Epidemiology and Disease Prevention (785) 296-6544

M. STD / AIDS DISEASE INTERVENTION / PREVENTION SERVICES

1. Awards will be initiated upon receipt of an amended budget based on the actual amount of the award unless award is equal to the requested amount.

2. **QUARTERLY**: submit a narrative progress report describing program activity relevant to contract objectives.

3. **QUARTERLY**: submit the Certified Affidavit of Expenditures (Attachment #4). Fiscal reporting instructions are explained in sections Q., R., and S.

4. At the time of diagnosis of HIV-infection, submit documentation of referral and/or service provision for the HIV-positive client using the CDC Case Report. See (Attachments #12).

5. **PROGRAM CONTACT PERSON**
   Derek Coppedge, Director, STD Section
   Bureau of Epidemiology & Disease Prevention
   (785) 296-6177

N. HIV/AIDS CASE MANAGEMENT/PREVENTION CASE MANAGEMENT

1. Awards will be initiated upon receipt of an amended budget based on the actual award unless the award is equal to the requested amount.

2. **QUARTERLY:** submit a quarterly client activity report for the first, second, third, and fourth quarters for HIV/AIDS Case Management. See (Attachment #13). Quarterly reporting of Prevention Case Management narrative and client activity must be reported in the KDHE Evaluation Web System as soon as possible after activity performed.

3. **ANNUALLY:** at the end of the fourth quarter, submit a CARE Act Data Report (CADR) for HIV/AIDS Case Management provided by KDHE and HRSA. The annual narrative with client activity for Prevention Case Management must be completed in the KDHE Evaluation Web System.

4. **QUARTERLY:** submit the Certified Affidavit of Expenditures (Attachment #4). Fiscal reporting instructions are explained in sections Q., R., and S.

5. **PROGRAM CONTACT PERSON**

Angela Toney, Director
HIV/AIDS Case Management/Prevention Case Management
Kansas Ryan White Title II CARE Program
Bureau of Epidemiology & Disease Prevention
(316) 337-6136
Email: atoney@kdhe.state.ks.us

David Tritle, Director
Ryan White Title II CARE/AIDS Drug Assistance Program
Kansas Ryan White Title II CARE Program
Bureau of Epidemiology & Disease Prevention
(785) 296-8701
Email: dtritle@kdhe.state.ks.us

O. IMMUNIZATION ACTION PLAN (IAP)

1. **QUARTERLY**: submit the Certified Affidavit of Expenditures (Attachment #4). Fiscal reporting instructions are explained in sections Q., R., and S.

2. **BIANNUALLY**: submit a progress report of grant activities.

3. **PROGRAM CONTACT PERSON**
   Sue Bowden, Director
   Immunization Program
   Bureau of Epidemiology & Disease Prevention
   (785) 296-0687

P. CHRONIC DISEASE RISK REDUCTION (CDRR) AND/OR ENHANCEMENT GRANT PROGRAM REPORTING REQUIREMENTS

The following reports will be required by recipients of either CDRR or Enhancement grants semi-annually. Complete the provided Reporting Form (attachment #9) and Affidavit of Expenditure (attachment #4) for:

- The period of July 1, through December 31, 2005 and submit no later than January 15, 2006.
- The period of January 1, through June 30, 2006 and submit no later than July 15, 2006.
- Send one copy of the Reporting Form and Affidavit of Expenditure to your Outreach Coordinator (See Tobacco Use Prevention Program District Map).

Send one copy of the Reporting Form, the original Affidavit of Expenditures and one copy of the Affidavit of Expenditures to:

Kevin Shaughnessy
Kansas Department of Health and Environment
Internal Management/Accounting Services
1000 SW Jackson Ave., Suite 570
Topeka, KS 66612-1368

FISCAL REPORTING:

Q. FISCAL REPORTING REQUIREMENTS:

1. The appropriate Certified Affidavit of Expenditures (Attachments #1, #2, #4, or #7) is to be submitted on a quarterly basis. These affidavits can also be downloaded from the KDHE Website at: **http://www.kdhe.state.ks.us/doc_lib/index.html**

PLEASE DESTROY ALL PREVIOUS AFFIDAVIT FORMS AND USE THOSE THAT ARE IN THE ATTACHMENTS SECTION OF THIS BOOKLET AND THE KDHE WEBSITE.

IF YOUR AGENCY ELECTS TO PLACE THE FORM ON YOUR COMPUTER, PLEASE BE SURE THAT THE FORM IS IDENTICAL TO THE ONE SUPPLIED BY KDHE AND REMAINS LEGIBLE.

2. The affidavit must report all **actual expenditures** of the contract/grant program and separate them between State (grant) expenditures and Local expenditures. The contract should be reviewed to determine the amount of Local match required. **The local match contract requirement may be exceeded but cannot be less than the contract amount**. (Attachment #10)

Indirect cost and contributions **are acceptable as part of the matching fund only** after the local health agency has submitted **an annual indirect cost proposal** which meets State Agency requirements. Expenditure items included as indirect in the indirect cost computation cannot be included as direct cost items.

Most federal grant awards have a fiscal year from October 1 to September 30. When planning the program expenditures **do not anticipate receiving more than 25% of the grant funding for the period July 1 through September 30 (REFER TO THE INDIVIDUAL CONTRACT ATTACHMENT AND/OR NOTICE OF GRANT AWARD AMOUNT & SUMMARY OF PROGRAM OBJECTIVES).**

The local match (attachment #10) amount must be equal to or greater than the minimum required match for the same period. An excess match in the period starting October 1 will not be carried back to offset an under match for the period July 1 through September 30.

3. The expenditures reported on the affidavit must be in agreement with expenditures entered on the grantee books of account

4. List each capital equipment item (items costing $500 or more with a useful life greater than one year) purchased from State (grant) funds separately must be approved in advance by the KDHE Program Manager. Capital equipment

(items costing $5,000 with a useful life greater than one year) must be listed in the state capital equipment inventory. **Copies of paid invoices for such items must be attached. Please include the make, model and serial number of the item, if appropriate.** You may need to attach this information on a separate sheet. Capital expenditures entirely from the local funds do not require a copy of the invoice as such items will not be carried on the state inventory.

5. The affidavit must be signed by a person authorized by the Local Health Agency to sign agency documents. If you are reporting electronically, the name of the authorized person must be typed on the appropriate line.

6. The State Formula Fund Affidavit of Expenditures (Attachment #1) will be used to document accomplishments achieved with State Formula Funding and to maintain the Statutory Maintenance of Effort requirement.

The statute authorizing the State Formula Grant, K.S.A. 65-241 et seq., requires an amount from local tax revenues and from federal revenue sharing funds equal to or greater than the amount of the Formula Grant. "Moneys available under the act for financial assistance to local health departments shall not be substituted for or used to reduce or eliminate moneys available to local health departments from the federal government or substituted for or used to reduce or eliminate moneys available from local tax revenue . . . "The statute K.S.A. 65-242, as amended, provides that "If local tax revenues allotted to a local health department for a fiscal year fall below the level of local tax revenues allotted to the local health department for the preceding fiscal year, the amount of state financial assistance under this act for which such local health department is eligible for the fiscal year shall be reduced by a dollar amount equal to the dollar amount of reduction in local tax revenue for that fiscal year."

Enter in the "Maintenance of Effort" column on Line 8, "Other," the total expenditures, for the reporting period, from Local Tax sources and Federal Revenue Sharing. The "Maintenance of Effort" expenditures do not need to be reported categorically (e.g., Salaries, Travel, etc.), however the State (grant) expenditures must be reported categorically (e.g., Salaries, Travel, etc.). The total amount of Local Tax and Revenue Sharing expenditures should be entered even if a part of the expenditures is shown as match on Certified Affidavit of Expenditures forms for other grants. See Attachment #1.

7. The Affidavit of Revenues and Expenditures (Attachment #7) must reflect all program revenue for the current quarter of reporting. The amounts should be supported in your agency accounting records.

When reporting the **1st quarter of a new state fiscal year**, Program Revenue (Line 4, Box B) should have the Remaining Balance brought forward from the prior affidavit, Line 14, Box B. **The State Grant award amount** (Line

4, Box C) **will be zero (0)**. All other quarters of the state fiscal year (2nd, 3rd and 4th), Line 4, Boxes B and C, should have a balance brought forward from the prior affidavit report. Line **14 B and C cannot be a negative amount**. If the report just completed is for the 4th quarter of the fiscal year, carry forward only the remaining balance for "Program Revenue," Line 14, Box B to Line 4, Box B of the 1st quarter of the new state fiscal year. Line 14, Box C (State Grant Remaining Balance) ended with the state fiscal year end and is not carried forward to the new state fiscal year.

If there is no "Program Revenue" (Box B), then there will not be any "Revenue Expenditure Amounts" reported in Line 8 through 12, Box B.

The Local Expenditure Amounts (Box A) and Revenue Expenditure Amounts (Box B) are added together in the consideration of meeting the required local matching amount for the individual grant programs.

CONTACT PERSON
Kevin Shaughnessy, Accountant
Internal Management/Accounting Services
1000 SW Jackson Ave, Suite 570
Topeka, KS 66612-1368
kshaughn@kdhe.state.ks.us
Phone: (785) 296-1507

R. INSTRUCTIONS FOR AFFIDAVIT OF EXPENDITURES

1. Print or type the name of the organization receiving the grant award. Please include the organization's phone number.

2. Print or type the reporting quarter, listing the months covered by the Affidavit. Please do not designate the quarter as 1st, 2nd, 3rd or 4th, due to the conflict between state, federal, and local fiscal years.

3. Print or type the contractual title of the grant award **EXACTLY as it appears on the contract/attachment.** You may want to even identify the report by the Contract Attachment Number.

4. Record in the appropriate space(s) the actual salaries including fringe benefits paid to employees that are chargeable to the project. **NOTE**: All salary amounts charged must be supported in your agency accounting records by the individual employee time sheets.

5. Record in the appropriate space(s) any authorized travel chargeable to the project. **NOTE**: All travel charged against the State Grant Award must be supported in your agency accounting records by the traveling employee's time sheet.

6. Record in the appropriate space(s) the supplies amount chargeable to the project, as supported by your agency accounting records.

7. Record in the appropriate space(s) any Capital Outlay (items costing $500 or more with a useful life greater than one year) chargeable to the project. **NOTE**: All Capital Outlay expenditures charged against the State Grant Award must be authorized in the grant award contract or authorized by the State Program Director in writing with a copy of the Director's authorization attached to the Affidavit. Copies of the invoices for such items must be attached. **Include the make, model and serial number of the item, if appropriate. Reports received reflecting the purchase of a capital outlay without the appropriate copy(ies) of invoices will be delayed in processing.**

   Capital expenditures entirely from the local funds do not require a copy of the invoice as such items will not be carried on the state inventory.

8. Record all other expenditures in the appropriate space(s) that are chargeable to the project, as supported by your agency accounting records. **NOTE: Items and their cost(s) are to be listed individually**, except for the local effort on the State Formula affidavit which can be identified as "Total Maintenance of Effort."
9. Add lines 4 through 8 under each column for the Affidavit Total. **NOTE**:

The amounts in Local Match Amount Column (Maintenance of Effort on State Formula) plus Grant Amount column should equal the total in Total Amount Column.

10. The affidavit must be signed and dated by a person authorized by the Local Health Agency to sign agency documents. If you are reporting electronically, the name of the authorized person must be typed on the appropriate line.

CONTACT PERSON

Kevin Shaughnessy, Accountant
Internal Management/Accounting Services
1000 SW Jackson Ave, Suite 570
Topeka, KS 66612-1368
kshaughn@kdhe.state.ks.us
Phone: (785) 296-1507

S. FISCAL FOLLOW-UP:

1. Backup invoices and other supporting documentation are not to be submitted with quarterly affidavits unless specifically requested by the Department of Health and Environment. (See S. 7.) Copies of the invoices of all capital outlay expenditures charged against the State Grant Award must be submitted. Copies of the Purchase Request are not sufficient. Please include the make, model and serial number of any capital equipment item on the affidavit of expenditure, or on a separate sheet of paper identifying the items, and submit a copy of the invoice.Capital expenditures entirely from the local funds do not require a copy of the invoice as such items will not be carried on the state inventory.

2. Affidavits will be audited for:
   a. Mathematical accuracy
   b. Local match or maintenance of effort requirements (attachment #10)
   c. (Electronic) Signature

3. Each contractual agreement requires an audit in accordance with the Federal Single Audit Act of 1984 and OMB Circular No. A-133, Audits of States, Local Governments, and Non-Profit Organizations, and to **submit one complete copy** of the audit report to the State Agency within 12 months after the end of the Local Health Agency's fiscal year. **PLEASE BE SURE THAT YOUR MOST CURRENT COPY OF YOUR AGENCY'S AUDIT REPORT IS ON FILE WITH KDHE (Kevin Shaughnessy, Accounting Services, Suite 570), IF APPLICABLE.**

Audit exceptions appearing in the Local Health Agency systemwide audit report will be followed up by the Department of Health and Environment and reimbursements requested if necessary.

CONTACT PERSON
Kevin Shaughnessy, Accountant
Internal Management/Accounting Services
1000 SW Jackson Ave, Suite 570
Topeka, KS 66612-1368
kshaughn@kdhe.state.ks.us
Phone: (785) 296-1507

APPENDIX

CONTACT NAMES OF KDHE STAFF

Please use the KANS-A-N system when it is available.

Fiscal Reporting

Affidavits - Budgets - Audits - Payments-
Kevin Shaughnessy ..... (785) 296-1507

Program Reporting

AIDS Case Management - David Tritle..... (785) 296-8701
- Angela Toney ..... (316) 337-6136
AIDS Counseling/Testing - Jennifer Vandevelde..... (785) 296-6544
AIDS HE/RR - Kathy Donner..... (785) 296-5223
- Ron Miller ..... (785) 296-6542
- Mary Sutton..... (316) 337-6135
Child Care Licensing & Registration - Janet Newton ..... (785) 296-1270
Chronic Disease RR - Carol Cramer..... (785) 368-6308
Family Planning-
Janis Bird..... (785) 296-1205
Ruth Werner ..... (785) 296-1304
Immunization Action Plan (IAP) - Sue Bowden ..... (785) 296-0687
Maternal and Child Health-
Child Health - Chris Tuck..... (785) 296-7433
Adolescent Health - Jane Stueve ..... (785) 296-1308
Perinatal Health - Joe Kotsch..... (785) 296-1306
Comprehensive School Health Centers - Jane Stueve ..... (785) 296-1308
Primary Care Clinic Program - Barbara Gibson..... (785) 296-1200
State Formula Funds - Shirley Orr..... (785) 296-1200
STD/AIDS Disease Intervention Spec - Derek Coppedge ..... (785) 296-6177
Teen Pregnancy Case Management - Jane Stueve ..... (785) 296-1308
Teen Pregnancy Prevention Peer Ed - Jane Stueve ..... (785) 296-1308
Teenage Pregnancy Reduction - Jane Stueve ..... (785) 296-1308

ATTACHMENTS